No. .....

IN THE

SUPREME COURT OF THE UNITED STATES

October, 1993, Term

A. JOHN GEIGER, Petitioner,

vs.

NEW YORK LIFE INSURANCE
COMPANY, Respondent.

PETITION FOR WRIT OF CERTIORARI

To The Court of Appeals,
10th Circuit

PETITION FOR WRIT OF CERTIORARI

A. JOHN GEIGER, Pro Se
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33pp

QUESTIONS PRESENTED FOR REVIEW

A. Did the Court of Appeals, 10th Circuit, err in sustaining the District Court application of Federal Rules of Civil Procedure 56 (c) to the material and undisputed facts.

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OPINIONS BELOW

Decisions of the trial court, Court of Appeals are contained in the appendix, and are unpublished.

JURISDICTION

Jurisdiction is conferred by U.S.C. 28 Section 1254 after a petition for a rehearing was denied on May 6, 1993, by the Court of Appeals, 10th Circuit.

SUPREME COURT RULE 14 (f)

The case involves application of FRCP 56, in particular 56 (c) to the undisputed facts in this in this case:

> (c) Motion and Proceedings thereon. The motion shall be served at least 10 days before the time fixed for the hearing. The adverse party prior to the day of hearing may serve opposing affidavits. The judgement sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, SHOW THAT THERE IS NO GENUINE ISSUE AS TO ANY MATERIAL FACT AND THAT THE MOVING PARTY IS ENTITLED TO A JUDGMENT AS A MATTER OF LAW. A summary judgment, interlocutory in character, may be rendered on the issue of liability

alone although there is a genuine issue as to the amount of damages.

REASON RELIED ON FOR ALLOWANCE OF THE WRIT

Petitioner relies upon Supreme Court Rule 10.1 (a) which states in part:

> "....or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's power of supervision."

STATEMENT OF CASE

The petitioner purchased from respondent a disability income protection policy solicited and recommended by respondent agent previously when petitioner purchased a major medical policy from Golden Rule through the agent. The application contained misrepresented financial information and did not acknowledge a diagnostic x-ray study from twenty one (21) months before.

The petitioner experienced strokes on the 5th and 6th of December, 1990, paralyzing his right side totally disabling him. A

notice of claim was submitted to respondent on 2nd day of January, 1991, followed by a proof of claim on 24th day of February, 1991. The respondent requested seven previous years federal income tax returns which were not timely provided to petitioner by the agent (work copies were in her possession) for quick submission to the respondent, but finally were received by petitioner and submitted to respondent by the 24th day of March, 1991. The claim had not been denied or approved at the time this action was filed in State District Court, Garvin County, Oklahoma, on August 15, 1991.

The respondent removed the case to Federal District Court, Western District of Oklahoma, for diversity whereupon the initial defense response included a contention that misrepresentation made the claim void.

The trial court acting on an petitioner motion for partial summary judgement and an respondent motion for summary judgement dis-

missed the case on April 7, 1992. The petitioner appealed to the Tenth Circuit Court of Appeals which sustained the District Court ruling and denied a petition for rehearing.

UNDISPUTED FACTS CONSIDERED BY THE TENTH CIRCUIT COURT OF APPEALS

1. The application misrepresented the 1988 and 1989 income of petitioner.
2. The application did not acknowledge a cervical myelogram done on petitioner in January 1989.
3. The petitioner knew the application income was inaccurate.
4. The respondent agent had sold a major medical policy on October 18, 1990 to petitioner.
5. The respondent agent was the estranged wife of petitioner.
6. The respondent continued to withdraw premiums through February 1992, for 13 months after notice of claim and 5 months following the

respondent's initial response to the Federal District Court in which respondent alleged the policy was void because of misrepresentation. The petitioner would argue that retention of premiums is distinct from continuing to solicit premiums while simultaneously contending claim is invalid. All 14 months solicited and paid premiums were refunded on February 24, 1992.

UNDISPUTED FACTS NOT CONSIDERED BY THE TENTH CIRCUIT COURT OF APPEALS

1. The agent was a fully trained field agent of the respondent.

2. The agent was and is a Certified Public Accountant.

3. The agent had prepared for and jointly filed with petitioner the federal tax returns for 1988 and 1989 which is the documentary evidence for the application financial misrepresentation.

4. The agent had prepared and submitted to respondent a major medical claim form for the cervical myelogram.

5. The agent deceived the respondent on the "agent's statement" submitted with the petitioner's application by the following:

   a. By denying any legal relationship to applicant since the divorce was not granted until February 15, 1991.

   b. The agent checked a block denying any information not contained in the application which could b pertinent to the risk assumed by the respondent.

6. The respondent had notice of the misrepresentation with receipt of the tax returns and notice of

alleged agent fraud by phone on June 26, 1991, and by letter of July 26, 1991.

7. The petitioner had newly acquired income from a lateral career move to an emergency room physician which he earned $3,740.00 in October, 1990, and $5400.00 in November, 1990, and was scheduled to work shifts in December 1990 for $6,000.00.

8. The only effort to investigate the claim besides document requests was a peculiar written inquiry to the agent by Senior Claims Adjuster, Gloria Phelps, on May 7, 1991. The petitioner was never queried in person, by phone nor by correspondence.

9. The agent in a separate action deposition has now admitted that

both she and petitioner forgot about the myelogram.

Oklahoma Law recognizes three reasons explicitly and exclusively wherein a carrier can rescind a policy because of misrepresentation. In this case, these either all apply or none apply, depending upon the undisputed facts selected for consideration. And Oklahoma Law requires a carrier to diligently investigate a claim and separately to notify a claimant in writing of the reasons for any delay in claim settlement. The respondent did finally provide reasons on June 18, 1991, with correspondence from Phelps.

The petitioner argues that the Tenth Circuit Court of Appeals erred when it sustained the ruling of the trial court which was based on a selective and prejudicial use of material and undisputed facts. The petitioner argues that the apparent intentional exclusion of the agents statement

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had the effect of avoiding the question of who initiated and perpetrated the fraud and the issue of what the petitioner knew or should have known of the intent of the agent to deceive her principal. Another example is the separation of the petitioner's deposition testimony of his knowledge of the inaccuracies from his testimony that he was persuaded by the agent the inaccuracies were required to represent his situation.

When there is a genuine issue as to ANY material fact in the application of summary judgment under FRCP 56, the moving party is not entitled to a judgment as a matter of law. The petitioner argues that the Tenth Appeals Court erred when it sustained the trial court's selective use of material facts in its decision on at least the respondent's motion, if not both.

The petitioner petitions for a Writ of Certiorari from the Supreme Court under SC Rule 10 1(a) to correct the sanctioning of

ABLE COPY

"....such a departure by a lower court, as to call for an exercise of this Court's power of supervision."

The foregoing Petition was prepared by A. John Geiger, DO and I swear that it is true to the best of my knowledge.

A. JOHN GEIGER, D.O.,
PRO SE

CERTIFICATE OF SERVICE-MAILING
OR DELIVERY OF PETITIONER
PETITION FOR A WRIT OF CERTIORARI

This is to certify that a true and correct copy of the above petition for a writ of certiorari to the United States Supreme Court was mailed, first class, postage prepaid, on this 16 day of August, 1993, to:

R. C. Ford and M. W. Evans, of
CROWE AND DUNLEVY, P.C.
1800 Mid-America Tower
20 North Broadway
Oklahoma City, Oklahoma 73102

John Geiger DO

A. JOHN GEIGER, D.O.,
PRO SE

STATE OF OKLAHOMA)
) ss.
COUNTY OF CLEVELAND)

Subscribed and sworn to before me on this 16th day of August, 1993.

(Seal)

Joyce L. Blalock
NOTARY PUBLIC

MY COMMISSION EXPIRES:
December 23, 1996

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

A. JOHN GEIGER, Plaintiff-Appellant,	)	
v.	)	No. 92-6171 (D.C.No.CV-91-1472-C) (W.D. Okla.)
NEW YORK LIFE INSURANCE COMPANY, Defendant-Appellee.	)	

ORDER AND JUDGMENT*

Before LOGAN and MOORE, Circuit Judges, and BELOT,** District Judge

**Honorable Monti L. Belot, District Judge, United States District Court for the District of Kansas, sitting by designation.

After examining the briefs and appellate record, this panel has determined unanimously that oral argument would not materially assist the determination of this appeal. See

* This order and judgment has no precedential value and shall not be cited, or used by any court within the Tenth Circuit, except for purposes of establishing the doctrines of the law of the case, res judicata, or collateral estoppel. 10th Cir. R 36.3.

Fed. R. App. P. 34(a); 10th Cir. R. 34.1.9. The case is therefore ordered submitted without oral argument.

In this diversity action, plaintiff appeals form the district court's order denying his motion for partial summary judgment and granting defendant's motion for summary judgment. Plaintiff asserted two claims under Oklahoma law: 1) a breach of contract cause of action based upon defendant's failure to pay benefits under a disability insurance policy; and 2) a tort cause of action alleging defendant acted in bad faith in denying the disability claim. The district court concluded that defendant was entitled to rescind the disability policy because plaintiff had misrepresented his income on the insurance application and that defendant had not acted in bad faith.

This court reviews a district court's summary judgment decision de novo, Applied Genetics Int'l. Inc. v. First Affiliated

Sec., Inc., 912 F.2d 1238, 1241 (10th Cir. 1990), viewing the record in the light most favorable to the nonmoving party, Deepwater Invs., Ltd. v. Jackson Hole Ski Corp., 938 F.2d 1105, 1110 (10th Cir. 1991). Summary judgment is appropriate only if there is no genuinely disputed material issue of fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). On the other hand, Rule 56 precludes summary judgment if there is evidence before the district court "such that a reasonable jury could return a verdict for the nonmoving party." Anderson v. Liberty Lobby, Inc., 447 U. S. 242, 248, 91 L.Ed. 2d 202, 106 S. Ct. 2505 (1986). Upon consideration of record and the parties' arguments on appeal, we affirm the district court's decision.

The following facts are undisputed: Plaintiff applied for and obtained a disability insurance policy from defendant on November 5, 1990. Plaintiff's former wife,

who was one of defendant's agents, assisted him in completing the application. Plaintiff misrepresented several facts on the application, including his income for the previous two years. He asserted that his 1988 earned income was $58,000 and his 1989 earned income was $55,000. In fact, plaintiff's 1988 income was only $13,326.38, while his 1989 income was $10,731.71. Plaintiff knew, at the time he signed the application, that the income information was false.

Defendant would not have issued a disability policy to anyone who earned less than $16,000 annually. Further, in order to qualify for the amount of benefits offered by the policy plaintiff purchased, an individual would have to make at least $52,000 a year.

One month after defendant issued the policy, plaintiff suffered a stroke. He subsequently filed a "Notice of Claim" on February 26, 1991. The parties corresponded from January through July 1991 concerning

this claim. In August, plaintiff, having not received payment of any disability benefits, commenced this action in Oklahoma state court. Defendant subsequently removed the action to federal court. Following plaintiff's deposition, conducted in January 1992, defendant, on February 24, 1992, rescinded the policy and tendered to plaintiff a check representing the premiums paid on the policy, plus interest.

On appeal, plaintiff first argues that defendant was not entitled to rescission because, at the time it issued the policy, defendant has knowledge, imputed to it from defendant's agent, of plaintiff's true income. The general rule is that "knowledge obtained by an agent of an insurer while acting within the scope of his authority is imputed to the insurer." Mutual Life Ins. Co. v. Bohlman, 328 F.2d 289, 294 (10th Cir. 1964) (applying Oklahoma law). The purpose of this general rule is to allow an innocent

third party to presume that the agent will perform his duty and report to the insurer all the facts that affect its interests. Id. This general rule does not apply, however, "when the third party knows there is no foundation for the ordinary presumption-when he is acquainted with circumstances plainly indicating that the agent will not advise his principal - as [the rule] is intended to protect those who exercise good faith, and not as a shield for unfair dealing." Id. An agent's knowledge, therefore, will not be imputed to the insurer if the applicant knows, or should know, that the agent is not going to transmit the correct information to the insurer and that the insurer is being deceived. See id. at 295; Motors Ins. Corp. v. Freeman, 304 P.2d 328, 330-31 (Okla. 1956).

In this case, the parties do not dispute that plaintiff's application contained inaccurate income information. At his depo-

sition, plaintiff indicated that, although his former wife filled out the application, he watched her make the entries. He further testified that he was aware that the income figures included in the application were inaccurate when he signed the application.

Plaintiff argues that, despite these undisputed facts, a reasonable jury might still believe that he was unaware that defendant would be deceived by this false information. Even in light of those undisputed facts, the record does not contain sufficient evidence to enable a reasonable jury to find in favor of plaintiff on this issue. Summary judgment for defendant on the issue of rescission, thereof was appropriate. Anderson v. Liberty Lobby, Inc., 477 U.S. at 251.

Plaintiff nonetheless argues that defendant is estopped from, and has waived its right to, rescind the insurance policy because defendant continued to accept plain-

tiff's monthly premium payments until February 1992. In order to rescind an insurance policy, Oklahoma law requires that the insurer act promptly, after acquiring knowledge of facts supporting rescission, to notify the insured of its intention to rescind the policy and to tender the return of the unearned premiums the insurer has received. Okla. Stat. tit. 15, Section 235; see also Great Am. Reserve Ins. Co. v. Strain, 377 P.2d 583, 587-88 (Okla. 1962). Retention of premiums prior to the insurer's acquiring actual knowledge of facts to rescind the policy. See United States Casualty Co. v. Jackson, 46 P.2d 939, 942 (Okla. 1935).

An insurer will be entitled to rescind a policy if an applicant makes a material misrepresentation in his insurance application which is fraudulent, or material to the risk accepted by the insurer, or if the insurer, in good faith, would not have issued the

policy if it had known the true facts. Dennis v. William Penn Life Assurance Co., 714 F. Supp. 1580, 1582 (W.D. Okla. 1989) (citing Okla. Stat. tit. 36. Section 3609). The insurer must establish, among other things, that the applicant made those misrepresentations knowing at the time that they were false. Id.

Plaintiff argues that defendant possessed sufficient facts to rescind the insurance policy in April 1991, when it received copies of plaintiff's tax returns for the years in question. Because defendant, nonetheless, waited until February 1992 to rescind the policy, plaintiff contends it waived its right to do so.

Although defendant did possess information, in April 1991, indicating a discrepancy existed between the income figures plaintiff reported on his tax returns and the figures he included on the insurance application, defendant did not possess facts indicating

plaintiff knowingly made those misstatements until he admitted doing so during his deposition in January 1992. Defendant rescinded the policy and tendered the return of the premiums within a reasonable time after that deposition. The fact that defendant rescinded the policy during the course of litigation is not determinative. See Jackson, 46 P.2d at 942 (when insurer obtains knowledge of facts supporting rescission during course of litigation, tender of return of premiums during pendency of legal action not unreasonable).

Lastly, plaintiff asserts that the district court erred in granting defendant summary judgment on a bad faith tort claim. Where, as here, however, the insured does not have a valid claim for benefits under the policy, a bad faith claim will not lie. See Dennis, 714 F. Supp. at 1584. The district court, therefore, did not err in granting defendant summary judgment on the tort claim.

Plaintiff's remaining arguments lack merit. The judgment of the United States District Court for the Western District of Oklahoma is, therefore, AFFIRMED.

The mandate shall issue forthwith.

Entered for the Court

Monti L. Belot
District Judge

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

A. JOHN GEIGER,	)	
	)	
Plaintiff-Appellant,	)	
	)	
v.	)	No. 92-6171
	)	
NEW YORK LIFE INSURANCE COMPANY,	)	
	)	
Defendant-Appellee.	)	

ORDER
Entered May 6, 1993

Before LOGAN, MOORE, Circuit Judges, BELOT, *District Judge.

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*Honorable Monti L. Belot, District Judge, United States District Court for the District of Kansas, sitting by designation.

This matter comes on for consideration of appellant's petition for rehearing.

Upon consideration whereof, the petition for rehearing is denied.

Entered for the Court

ROBERT L. HOECKER, Clerk

By: S/Patrick Fisher
Chief Deputy Clerk

IN THE UNITED STATES COURT FOR THE
WESTERN DISTRICT OF OKLAHOMA

A. JOHN GEIGER,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. CIV-91-1472-C
	)	
NEW YORK LIFE	)	
INSURANCE CO.,	)	
	)	
Defendant.	)	

ORDER

This matter is before the Court for consideration of cross-motions for summary judgment. Both parties have responded and the case is now at issue.

In plaintiff's motion for partial summary judgment, he offers two propositions. First, for its failure to pay plaintiff's insurance claim, the defendant New York Life Insurance Company ("New York Life") should be found guilty of unfair trade practices. Secondly, New York Life no longer has a right to cancel or rescind the insurance contract as it has continued to accept monthly premiums for insurance coverage, has not noti-

fied him that his insurance policy was voided or canceled, and has not refunded his premiums. In response, New York Life states it rescinded the policy following an investigation and returned all premiums. Moreover, Geiger has since given deposition testimony that he did receive notice within thirty days.

In the motion for summary judgment filed by New York Life, it argues the material misrepresentations made by Geiger in his insurance application justify its denial of benefits. Additionally, defendant challenges Geiger's attempt to impute to New York Life the knowledge of its agent who apparently knowingly participated in the submission of misstatements to New York Life.

The material facts pertinent to resolution of the motions for summary judgment are not in dispute and are listed below:

1. On November 5, 1990, Geiger submitted to New York Life an application for

income protection disability insurance, together with a payment for the first month's premium.

2. Marilyn Geiger, plaintiff's wife, was the New York Life agent who assisted in the preparation and submission of the insurance application.

3. In his insurance application, Geiger stated in 1989 his net earned income for personal federal income tax purposes was $55,000, and $58,000 in 1988.

4. Geiger's 1989 federal tax return for his corporation shows income of $10,731.71. The figure for 1988 is $13,326.38.

5. New York Life will not issue disability insurance to applicants whose annual earned income is less than $16,000.

6. The disability insurance policy for which Geiger applied would provide $3,000 per month for total disability.

7. To be qualified to receive monthly benefits of $3,000 under this type of a New York Life policy, the applicant's annual income must be $52,000.

8. In his deposition, Geiger testified the income figures stated in his insurance application are false and he knew these figures were false when he signed the insurance application.

9. In his insurance application Geiger stated in the last ten years he had not consulted a doctor nor had he been treated for back, spine, joint, or bone disorder. Further, Geiger stated in the past two years he had not had a diagnostic test.

10. In his deposition, Geiger testified the medical information on his insurance application is false as he had a cervical myelogram in 1989.

11. Geiger made application for disability benefits on January 2, 1991. New York Life sent a series of letters to plain-

tiff requesting additional information on the claims.

12. On February 24, 1991, New York Life sent notification to the plaintiff that the policy was being rescinded due to his omission of material information, and all premiums were returned with interest.

A. **Unfair Trade Practices**

Geiger asserts New York Life is guilty of unfair trade practices. He states defendant has violated Okla. Stat. tit. 36 Section 1219 as it "did not pay this claim by the 60 day limit set out in 36 Oklahoma Statutes, Section 1219," and because New York Life "did not notify plaintiff by certified or registered mail with return receipt within 30 days of receipt of the notice of claim that there would be a delay in the payment of his claim and the cause of the delay" (Plaintiff's Brief in Support of his Motion for Partial Summary Judgment, at pp. 3 and 4). However, in his deposition Geiger testified that fol-

lowing his January 2, 1991, Notice of Claim, New York Life on January 18, 1991, requested additional information (Deposition of A. John Geiger, pp. 118-120). (1/18/91 letter from New York Life to plaintiff to obtain "further information which we feel will be helpful in the consideration of this claim"). This was followed by additional requests for information (Deposition of A. John Geiger, pp. 120-123) (2/21/91 letter from New York Life to plaintiff in which it is stated "please refer to our request on 1/18/91. This information is still outstanding. After the information is received, we will continue our handling of your Disability claim.") On February 26, 1991, Geiger responded with his Proof of Claim. New York Life requested more materials and again asked Dr. Geiger to respond to its initial requests (Deposition of A. John Geiger, pp. 123-124, pp. 141-142) (3/16/91 and 4/2/91 letters from New York Life to plaintiff in which it is stated "We

need additional information from you. Please send us your complete ind. and corporate returns for 1990. All schedules and attachments. Thank you.") Dr. Geiger also testified that New York Life timely responded to his claim (Deposition of A. John Geiger, pp. 143-144).

New York Life concedes its correspondence was not sent by certified mail, but plaintiff did receive actual notice sufficient to satisfy the statue. See Howell v. Blue Cross & Blue Shield of Okla., 609 P.2d 1283, 1284 (Okla. 1980); and First National Bank v. Oklahoma Sav. and Loan Bd., 569 P.2d 993, 997 Okla. 1977). In any event, the requirement for statutory notice does not apply to situations where the claim is not valid. See Christian v. American Home Assur. Co., 577 P.2d 899, 903-904 (Okla. 1977); Dennis v. William Penn Life Assur. Co. of America, 714 P. Supp. 1580, 1584 (W.D. Okla. 1989). The Court finds the evidence estab-

lishes that New York Life in good faith continued to investigate plaintiff's claims and did not violate Okla. Stat. tit. 36 Section 1219.

B. Misstatements

Okla. Stat. tit. 36, Section 3609(A) permits rescission of an insurance policy where there have been misrepresentations, omissions, concealment of facts, and incorrect statements if these were:

> 1. Fraudulent; or
>
> 2. Material either to the acceptance of the risk, or to the hazards assumed by the insurer; or
>
> 3. The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

1. Lack of Reliance

In his first proposition in response to

New York Life's motion asserting its entitlement to rescind the policy for material misstatements, Geiger states his income exceeded the minimum $16,000.00. Geiger lists the following as his net income figures: 1990, $35,286.30; 1989, $28,731.71; and 1988, $23,644.61. (See Supplemental Affidavit of A. John Geiger filed March 4, 1992) Because each year's income exceeded $16,000, Geiger argues he should not be denied insurance coverage. In his second argument Geiger directs the Court's attention to the gross income for his clinic as being sufficient to meet the level for coverage. Geiger points out the affidavit of New York Life's representative does not indicate that to meet the minimum required the "net" income should reach a certain level. This ignores the plain language on the insurance application which states at 7.(b):

> EARNED INCOME - Earned income consists of wage, commissions and other amounts received for personal services, as reportable for person-

> al federal income tax purposes, after deducting normal business expenses. (emphasis added)

See also Section 2 - FINANCIAL INFORMATION

> EARNED INCOME - Fill in amounts as reportable by the Proposed insured for personal federal income tax purposes. (emphasis added)

As attested to in his affidavit, Geiger's net income figures fell almost $15,000 lower than the minimum necessary to warrant this size of policy. Moreover, as noted in the above passages, plaintiff did not insert the true figures in his insurance application. It is shocking that plaintiff acknowledges that "defendant has proven, and plaintiff admits" certain statements in the insurance application were "untrue", and then suggests "there is no evidence that the statements were false, fraudulent, misleading, were in bad faith and were relied upon by defendant." On balance, the Court finds the evidence in fact shows all of the above.

New York Life has established it would not issue a disability insurance policy to an

individual whose income is less than $16,000. Further, to qualify for $3,000 in monthly benefits from New York Life, an individual's income must exceed $52,000. The evidence clearly shows Geiger has violated the sections of Okla. Stat. tit. 36, Section 3609 cited above which entitles New York Life to rescind the policy at issue here.

2. Estoppel

In Geiger's second proposition, he challenges New York Life's ability to avoid coverage on the basis that the agent knew the true facts. As a general rule, in the absence of fraud or collusion the knowledge an agent obtains within the scope of his authority is imputed to his principal. Motors Ins. Corp. v. Freeman, 304 P.2d 328 (Okla. 1956). There is an exception to this general rule where "the circumstances are such that the agent would not communicate such knowledge to the principal" and "in the absence of proof that the applicant knew, or

should have known, that the company was being deceived." Id., at 330-331. See also Mutual Life Ins. Co. of New York v. Bohlman, 328 F.2d 289 (10th Cir. 1964). By Geiger's own admissions, here we do not have a situation where the applicant answers questions contained in an application for a policy of insurance, fully and without withholding material facts, and the agent does not correctly write such information in answer to the questions propounded. Atlas Life Ins. Co. v. Sullivan, 52 P.2d 28 (Okla. 1935), as cited in National Life & Accident Ins. Co. v. Hearn, 240 P.2d 83 (Okla. 1951). As stated in Bailey v. Gulf Ins. Co., 389 F.2d 889, 891 (10th Cir. 1968), appeal after remand, 406 F.2d 47 (10th Cir. 1968), "The Oklahoma Court has recognized the general principle that a man cannot serve two masters, but in actions on insurance policies has said that the rule does not apply unless (1) the agent has a direct pecuniary interest, (2) the agent has

a direct fiduciary relation which would imply an improper motive, or (3) the insured knew, or should have known, that the insurer was being deceived." Geiger admits not only that the information submitted in his insurance application is false, he knew of the falsity when he signed the document (Deposition of A. John Geiger, pp. 58-64).

Geiger argues the doctrine of estoppel bars New York Life's attempts to cancel or rescind the contract. In Geiger's opinion, because New York Life continued to accept the monthly insurance premiums it has waived its right to complain of Geiger's misrepresentations. New York Life objects to the inclusion of this matter in the Final Pretrial Order, filed April 2, 1992. In any event, New York Life has offered sufficient justification for its continued acceptance of Geiger's premiums: 1) within thirty days of Geiger's Notice of Claim, and again with his Proof of Loss, New York Life requested Geiger

submit additional information necessary to process his claim (Deposition of A. John Geiger, pp. 117-124, pp. 141-153); 2) Geiger and his expert witness both have testified that Geiger responded slowly to the requests for additional information (Deposition of A. John Geiger, p. 143; Deposition of John A. Hammand, pp. 23, 26-29); 3) New York Life's investigation of Geiger's claim was interrupted by Geiger's initiation of the present litigation (action filed on September 17, 1991 and notice of rescission given on February 24, 1992); 4) when New York Life finally obtained sufficient information to determine that Geiger made material misrepresentations in his application for insurance. New York Life rescinded the policy and returned all the premiums which Geiger had paid, with interest (Supplemental Affidavit of A. John Geiger, filed March 4, 1992). The Court finds there was a legitimate dispute with regard to whether Geiger had a valid

claim which is sufficient to warrant New York Life's delay in rescinding the policy of insurance and returning the premiums.

Additionally, Geiger states because he submitted bills for the hospital and doctor fees to his health insurance carrier, which coincidentally was also New York Life, the defendant was aware of Geiger's myelogram which occurred almost 22 months before Geiger applied for disability insurance. In this supplemental affidavit, Geiger states it was his wife's idea to misrepresent his income and medical information on the insurance application. Acknowledging the information in the application was false, Geiger does not offer anything in support of his misstatements other than it was the idea of his wife (and New York Life agent) to submit the false information. While this may be an explanation, it is not an excuse. Geiger knew the true facts. He knew before he signed the insurance application that the insurance ap-

plication contained false information. Nevertheless, Geiger signed the insurance application with full knowledge of the falsity contained in the insurance application. Accordingly, he cannot now be heard to complain that it was the agent who submitted the false information, inasmuch as he knew he submitted false information. To hold otherwise would be against not only the cases dealing with misstatements in insurance applications but public policy as well.

According, New York Life is entitled to rescind the policy as Geiger submitted an insurance application form containing information which he knew to be false, which representations were material to the acceptance of the risk or to the hazards assumed by the insurer, and upon which representation New York Life in good faith would not have issued the policy or would not have issued a policy in as large an amount if the true facts had been known. Further, New York Life in good

faith continued to investigate the validity of coverage for Geiger's claim, and plaintiff's claim for unfair trade practices and estoppel must fail.

In accordance with the foregoing, plaintiff's motion for pretrial summary judgment shall enter for defendant.

IT IS SO ORDERED this 7 day of April, 1992.

s/ROBIN J. CAUTHRON
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES COURT FOR THE
WESTERN DISTRICT OF OKLAHOMA

A. JOHN GEIGER,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. CIV-91-1472-C
	)	
NEW YORK LIFE INSURANCE CO.,	)	
	)	
Defendant.	)	

JUDGMENT

Upon consideration of the pleadings herein, the Court finds that plaintiff's motion for partial summary judgment is denied, and defendant's motion for summary judgment is granted. Judgment is therefore entered on behalf of defendant.

DATED this 7 day of April.

s/ROBIN J. CAUTHRON
UNITED STATES DISTRICT COURT